MICMT Annual Meeting
November 1, 2019

Topic Discussion Summary: A1c Performance

Processes:

- Ways to identify patients who have high A1C
  - Review ADT data – look for diagnosis of DKA
  - Registry – quality team creates a patient report A1C not controlled
    - Group reported a variety of cutoffs to make the "A1C not controlled" list _ ex. A1 C ≥ 8
  - Referral from physicians, staff
  - Review various reports – PO and practice level
  - Electronic referral
- Planned visit – review patients coming into clinic in following week
- DM group visit
- DM reversal – plant based diet, exercise. Focus is prevention
- Pharmacist embedded and centralized
  - Pharmacist sees patient when A1c is greater than 8
  - RN sees patient when A1c is less than 8

Barriers:

- Billing
  - Limited billing – 20 minute for Medicare
  - BCBSM out of state patients – cannot bill
  - Patients with Medicaid and practice does not participate in SIM
- Want practice to be all payer
  - If practices do not hit incentives, it's a struggle to cover expense of licensed FTEs
- Cost of medication
  - Medicare – fall in donut hole and patient is not able to afford insulin.
- Not employed physician practices
  - Not enough FTEs - care manager/team members
- No Community Health Workers in central Michigan (or very limited CHWs)
- Small rural practices without care managers – 1 physician practices
- Transportation for patients in rural area – a struggle to get to the physician appointment

- Patients need education – not understanding A1c
- When patients cannot cover cost of DM medication –
    - Practice provides samples: Inconsistency of DM medication samples – hard to show patient progress because the sample runs out in 3 months and no way to continue the medication even if it is effective for the patient

Solutions:

- Lake Huron PHO – Hosting the "Sugar and Spice Program"
    - Eye exam, A1c, foot exam
    - Education, endocrinologist, cooking demonstrations
    - Ophthalmologist and optometrist – includes having patient eye exam test info back to primary care
    - Independent 13 practices – marketing widespread for this 1st program offering
    - Future programs: will offer Q 6 months; target patients
    - Open to community
- CM or MA place post-it note on exam room door so physician knows patient's A1c is high and needs to be discussed with CM, or other reason patient needs to see CM
- Dry Erase board hot pink – provider writes note on Dry Erase hot pink to improve communication and let team know patient needs to see care manager. Patient takes the dry erase to check out staff
- Care manager flyer – trigger provider to introduce patient to care manager
- Team!
    - Multidisciplinary team - include dietitian, social worker, behavior health, RN, Pharm D, CDE
- Refer patients to Diabetes Prevention Program (DPP)
- Education days for the Multidisciplinary team
- Multipayer billing resource - All payer tool – coverage for care management services
- Billing alignment
- DM reversal
- PCP, pharmacist and RN CM work together:
    - Target patients using registry - target of A1C > 8
    - Pharmacist works with patients with uncontrolled A1C. Once the patient has 2 consecutive A1C results which are in control (i.e. over 3 to 4-month time period), transitions patient to the RN care manager
    - PCP and RN CM continue to work closely with the patient
- FQHC
    - One CDE in rural practice can see patients if they have the benefit
    - Patient without benefit – patient is referred to DM education program offered by the hospital
    - Target patients with A1c of $\geq$ 8

- If patient's A1C is not improved in 6 months, refers to specialist
- Community resources, ex. Fresh produce
- Newly diagnosed – all refer to DM education program, then to care manager